

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges County -City or town Chesley, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 day -

Hospital, institution, or street address where death occurred:

Prince George's General HospitalHow long in hospital or institution? 16 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges CountyCity or town Hyattsville, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 4005 Quintana St.
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Antenori, Mary Catherine

3. (b) Social Security Number

4. Sex Female5. Color or race White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 25 - 19468. AGE: Years Months Days 16
If less than one day _____ hrs. _____ min.9. Birthplace Chesley, Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Leo Louis Antenori13. Birthplace Scranton, Penna.14. Maiden name Catherine Albano15. Birthplace Graves Mill, Virginia16. Informant Leo Louis AntenoriAddress 715 Ridge Rd. Rockville, Pa.17. Burial Lincoln Date thereof May 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Washington, D.C.Location Washington, D.C.18. Funeral director F. Esche's sonsAddress Hyattsville, Md.19. 5/13/46 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 19 46, at 7⁵⁰ P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-25-46 19 46, to 5-10 19 46.and that I last saw h. cr alive on 5-9-46 19 46.Immediate cause of death Premature

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John P. Clum M.D.Address Hyattsville, Md. Date signed 5-11-46

RECEIVED
MAY 15 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

05018

★ Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgesCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 42 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)Street No. 3723-36th St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret E. Breen

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed6.(b) Name of husband or wife James A. Breen

6.(c) If alive, give age

7. Birth date of deceased (mo., day, yr.) November 5, 1858

8. AGE: Years Months Days If less than one day

87 yrs. 0 mos. 0 days9. Birthplace Alexandria, Virginia
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name John Stone13. Birthplace England14. Maiden name Ellen Hall15. Birthplace England16. Informant Lucille MetzgerothAddress 3723-36th St. Mt. Rainier, Md.17. Burial Date thereof May 28, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mt. Olivet CemeteryLocation Washington, D.C.18. Funeral director William J. NalleyAddress 3200-R.I. Ave. Mt. Rainier, Md.19. May 28 1946 James Bevery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1946 at 11³⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1944 to May 25 1946and that I last saw her alive on May 25 1946Immediate cause of death Myocardial failureDue to Cerebral apoplexy

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank R. Shea M.D.Address 4100-22nd St. EDate signed 5/27/46

RECEIVED

CENTRAL OFFICE OF DEATHS

RECEIVED

RECEIVED

MAY 30 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH:

County Prince Georges

City or town Greenbelt, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Beland Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)Street No. 132 Ridge Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Raymond Paul Brockway

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Mrs. Anne Rose Brockway

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1916

8. AGE: Years 29 Months 6 Days 27 hrs. min.

9. Birthplace Cambria, Penna.
(Town, county, and state)

10. Usual occupation Finger print analyst

11. Industry or business Federal Bureau of Investigation

12. Name George Brockway

13. Birthplace

14. Maiden name Jeanette Baumgartner

15. Birthplace ? Ohio

16. Informant Mrs. Anne Brockway (wife)

Address 132 Ridge Rd. Greenbelt, Md.

17. Burial Date thereof May 27, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Lincolns

Location Pr. Geo. Co., Md.

18. Funeral director W. W. Chambers Co.

Address Greenbelt, Md.

19. May 25 1946 James L. Sery
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1946 at 10:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 1945 to May 23 1946

and that I last saw him alive on May 23 1946

Immediate cause of death Respiratory failure

DURATION

Due to Pneumonia

Due to Metastatic Hodgkin's Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William L. Sery M.D. or other

Address 30 B Ridge Rd Date signed 5/23/46
Greenbelt Md

RECEIVED

MAY 25 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

05020242
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George
City or town Silver Hill, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution residence
3813 Branch Ave SE
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) 6 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Pr George
City or town Silver Hill Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3813 Branch Ave SE
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Julia Grant Brooks

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Edwin R Brooks

6. (c) If alive, give age 74 years

T. Birth date of deceased (mo., day, yr.) May 13, 1885

8. AGE: Years 61 Months 0 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Glasgow Scotland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

FATHER 12. Name Angus John Grant

13. Birthplace Glasgow, Scotland

MOTHER 14. Maiden name Julia

15. Birthplace Glasgow Scotland

16. Informant Mr. E. R. Brooks

Address (Husband)

17. Removal Date thereof May 14-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Washington D.C.

18. Funeral director The S.H. Jones Co.

Address 2901 14th St. N.W.

5-14- 19 46 Thos. D. Griffith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 46 at 8:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 4 19 40 to May 14 19 46 and that I last saw him alive on May 14 19 46

Immediate cause of death Acute long-term Heart Disease DURATION 24 hrs

Due to _____

Due to _____

Other conditions Hypertensive Pneumonia

basal pneumonia 19 42 yr

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. W. Schwab MD

Address 1220 Talbot St. E M. D. or other 8/14/46

Date signed 8/14/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAY 18 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1866

CERTIFICATE OF DEATH

Reg. Dist. No. 0562140

1. PLACE OF DEATH:

County..... Prince George
City or town..... Brandywine
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Prince George

City or town..... Brandywine
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Harold Brown

3. (b) Social Security Number

4. Sex..... Male
5. Color or race..... Colored
6. (a) Single, married, widowed, or divorced..... single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... Dec. 24 1918
8. (c) If alive, give age..... years

8. AGE: Years..... 27 Months..... 4 Days..... If less than one day..... hrs. min.

9. Birthplace..... Charles Co.
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business.....

12. Name..... William Brown

13. Birthplace..... Md.

14. Maiden name..... Grace W. Wells

15. Birthplace..... Md.

16. Informant..... Edward B. Brown

Address..... Croom, Md. 12/46

17. Burial..... Date thereof..... Mar 10 1946
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory..... St. Marys
Location..... Wayside, Md R.R. Co.

18. Funeral director..... J.B. Johnson

Address..... Annapolis

19. Date rec'd by registrar..... May 9 1946

Signature..... J.H. Billingsley
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 8 1946 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... DURATION.....

Due to..... Rupture of spleen
left lobe of lung. Rupture
of both lungs at base

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results..... as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of..... 5-8-46

Where did injury occur?..... Camp 3, Camp P. 9, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Andrews Field

Means of injury..... Crushed by lumber, injured at work? Yes

Reported medical examiner.....

23. SIGNATURE..... James D. Ford

Address..... Forestville, Md. Date signed..... 5-9-46



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

CERTIFICATE OF DEATH

Reg. Dist. No. 15022

Res. Dist. 705

1. PLACE OF DEATH:

County Prince Georges

City or town Leesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Leesville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) if veteran, name war

3. (a) FULL NAME

Thomas Brown

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male

Colored

Single

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March

1904

8. AGE:

Years

Months

Days

If less than one day

42

hrs.

min.

8. Birthplace Leesville, Md.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Farm

FATHER

12. Name William E. Brown

13. Birthplace

Maryland

MOTHER

14. Maiden name

Mary Kent

15. Birthplace

Maryland

16. Informant

William E. Brown

Address

Leesville, Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

5-31-46
(month) (day) (year)

Cemetery or crematory

Asbury

Location

Rural Methodist chh

18. Funeral director

Hunt & Ryan

Address

Waldorf Md

19.

(Date rec'd by registrar)

19.

46

M. P. Brown

Registrar

6-1-46

H. Billington

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1946 at 2:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

19.

and that I last saw h. alive on

19.

Immediate cause of death

Universal burns
of body

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tick in the following:

Accident, suicide, or homicide

Accident

Date of

5-31-46

Where did injury occur?

Leesville P. G.

(County)

(State)

Injured at home, farm, industry, public place (where?)

Home

Occupant of home

other than occupant

Report

medical examiner

23. SIGNATURE

James D. Brown

M.D. or other

Address

Leesville Md

Date signed

5-31-46

RECEIVED

JUL 2 1946

BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 874

CERTIFICATE OF DEATH

Reg. Dist. No. 150230

1. PLACE OF DEATH:

County Prince Georges
 City or town Berwyn
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 years
 Hospital, institution, or street address where death occurred:
Cherry Hill Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Berwyn
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Cherry Hill Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Nellie Cleveland Bunch

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Milton Bunch
 7. Birth date of deceased (mo., day, yr.) Aug 1, 1892 8. (c) If alive, give age 73 years
 8. AGE: Years 53 Months 3 Days 1 If less than one day
 hrs. min.

8. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name William H. Chelton
 13. Birthplace Virginia
 14. Maiden name Margaret Laws
 15. Birthplace Maryland

18. Informant Milton Bunch
 Address Berwyn, Md
 17. Burial Date thereof May 25, 1946
 (Burial, cremation, or removal, which?) (Month) (day) (year)
 Cemetery or crematory Parkwood Cemetery
 Location Baltimore Md

18. Funeral director F. Grachs son
 Address Hyattsville Md

19. May 25 19 46 Amanda Brown
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 19 46 at 11:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19 to 19
 and that I last saw him alive on 19

Immediate cause of death multiple sclerosis DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy Medical Examiner
James J. Bond
 M. D. or other

Address Frederick Md Date signed 5-23-46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAY 28 1945

BUREAU V F

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George'd
 City or town Glenn Dale - RURAL
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 100 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 100 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 517-2'd. N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

CLARENCE BURROUGHS

3. (b) Social Security Number

577-26-7076

4. Sex

male

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

-

7. Birth date of

deceased (mo., day, yr.)

Sept. 21, 1922

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

23

7

10

hrs.

min.

9. Birthplace

TB. Maryland

(Town, county, and state)

10. Usual occupation

cook

11. Industry or business

-

FATHER

12. Name

Alphonso Burroughs

13. Birthplace

?, Maryland

MOTHER

14. Maiden name

Mabel Pinkney

15. Birthplace

?, Maryland

16. Informant

deceased

Address

17.

Removal
(Burial, cremation, or removal. Which?)

Date thereof

5-1-46
(month) (day) (year)

Cemetery or crematory

Location

Removal to Washington

18. Funeral director

Address

John T. Phillips
901-3rd St. S.W.

19.

May 1, 1946
(Date rec'd by registrar)Rowland S. Phillips
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 1

19

46 at 3:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 21, 1946, to May 1, 1946
and that I last saw him alive on May 1, 1946

Immediate cause of death

Pulmonary tuberculosis

DURATION

3 1/2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinucane M.D.

M. D. or other

Address

Glenn Dale, Md.

Date signed 5/1/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 7 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1700

05025

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges
 City or town Pineville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Summer
 Hospital, institution, or street address where death occurred:
Telard Memorial Hospital
 How long in hospital or institution? 141

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Rhode Island County Providence
 City or town Providence
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 141 Congdon
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Jessie Gidley Carter

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov 28, 1875
 6. (c) If alive, give age 69 years

8. AGE: Years 70 Months 5 Days 26 It less than one day hrs. min.

9. Birthplace North Hallowell, Maine
 (Town, county, and state)

10. Usual occupation Retired Teacher

11. Industry or business

MOTHER FATHER
 12. Name Jessie Gidley
 13. Birthplace North Hallowell, Maine
 14. Maiden name Susannah Tucker
 15. Birthplace Conn.

16. Informant Walter W. Hule

Address 2 B. Woodland Way, Greenbelt, Md.

17. Transportation Date thereof May 28, 1946
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Wesley Funeral Home

Location New Bedford, Mass.

18. Funeral director F. J. Gash's Sons

Address Hyattsville, Ind.

19. 5/28 19. 46 Amelia Denny
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 19. 46 at 5:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 46, to 19. 46, and that I last saw him alive on 19. 46

Immediate cause of death

Hemorrhage
Shock

Due to Crushed chest

Fractured skull

Other conditions Compound fracture of

left femur Multiple lacerations
 (Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-26-46

Where did injury occur? Berwyn, P. D. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Prostration struck by car

23. SIGNATURE Amelia Denny M. D. or other Amelia Denny

Address Hyattsville, Ind. Date signed 5-26-46

CERTIFICATE OF DEATH

RECORDED
MAY 30 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Maryland - RURAL
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months, 14 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 5 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1818- R. Street, N.W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war -

3. (a) FULL NAME

JEAN B. CASTEIGNAU

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Annie Casteignau
 6. (c) If alive, give age 40 years
 7. Birth date of deceased (mo., day, yr.) January 16, 1902
 8. AGE: Years 44 Months 3 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace ? France
 (Town, county, and state)

10. Usual occupation butler

11. Industry or business -

FATHER 12. Name Bernard Casteignau
 13. Birthplace France

MOTHER 14. Maiden name Julia Cancan
 15. Birthplace France

16. Informant deceased
 Address _____

17. Burial Date thereof May 13, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cong. Washington Cemetery
 Location Prince George's County, Md.

18. Funeral director W.W. Chambers
 Address 1400 Chapin Rd. N.W.

19. May 11, 1946 Rowland S. Phillips
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 11, 1946 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 27, 1945 to MAY 11, 1946
 and that I last saw him alive on MAY 11, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 6 mo.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other _____

Address Glenn Dale, Md. Date signed 5/14/46

RECEIVED

MAY 24 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05026

Reg. Dist. No. 239

1. PLACE OF DEATH: Prince George
County
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs. 7 mos. 25 D
Hospital, institution, or street address where death occurred:
Laurel Sanatorium, Laurel, Maryland
How long in hospital or institution? 4 yrs. 7 mos. 25 D

2. USUAL RESIDENCE (HOME) OF DECEASED: Brothers
(For newborn infants give residence of mother)
State: Virginia County: Arlington
City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)
Street No. 205 W. Monroe Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William Preston Caton

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Widower
6. (b) Name of husband or wife Daisy E. Cade
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) September 10 - 1972
8. AGE: Years 73 Months 8 Days 8
It less than one day hrs. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Physician

11. Industry or business

12. Name James R. Caton

13. Birthplace Virginia

14. Maiden name Anne Greenway

15. Birthplace England

16. Informant Sanatorium Records

Address Laurel Sanatorium, Laurel, Maryland

17. Removal Date thereof May 20, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Alexandria, Va.

18. Funeral director J. S. Enuly

Address Alexandria, Va.

May 20 1946 M. Brachman

(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 19 1946 at 11:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23 1941 to May 19 1946
and that I last saw him alive on May 19 1946

Immediate cause of death
Cardiac De Compensation
DURATION 8 d

Due to General Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John L. Wethered

M. D. or other

Address Laurel Sanatorium Date signed 5/19/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

RECEIVED

MAY 23 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 139

CERTIFICATE OF DEATH

15027 232
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George
City or town Mitchellville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Mitchellville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Crain Highway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William J. Connors

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White married

6. (b) Name of husband or wife Emma D. Jerome

6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) April 29 - 1875

8. AGE: Years Months Days If less than one day
71 0 20 hrs. min.

9. Birthplace Mashtike, Tenn.
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Country Store

12. Name William J. Connors

13. Birthplace New Jersey

14. Maiden name Catharine Bonheur

15. Birthplace New Jersey

16. Informant Mrs. Emma D. Connors

Address Mitchellville, Md.

17. Cremation Date thereof 5-22-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Crematorium

Location Southland, Ind.

18. Funeral director Ritchie Brothers

Address Upper Marlboro, Md.

19. May 22 - 46 19 46 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 19 46 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 19 42 to May 19 19 46

and that I last saw him alive on May 18 19 46

Immediate cause of death

Cerebral Hemorrhage DURATION Week

Due to Hypertension

as a result of

Due to Dissecting 10 yrs

Other conditions Arteriosclerosis 12 yrs

(Include pregnancy within 3 months of death)

Major findings of operations none

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James R. Parker M.D. M. D. or other

Address Upper Marlboro, Md. Date signed 5-21-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 23 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1190

CERTIFICATE OF DEATH

05028

Reg. Dist. No.

231

1. PLACE OF DEATH:

County Prince GeorgesCity or town Chesley
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 hr. - 25 min.

Hospital, institution, or street address where death occurred:

Prince Georges General HospitalHow long in hospital or institution? 10 hrs. 25 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town 4313 Farragut St. Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Richard Cooper Jr.

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white single

8.(b) Name of husband or wife _____

8.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) December 11, 19458. AGE: Years Months Days If less than one day
5 16 10 hrs. 25 min.9. Birthplace D.C.
(Town, county, and state)10. Usual occupation none

11. Industry or business _____

12. Name Richard J. Cooper13. Birthplace Michigan, Wayne County14. Maiden name Peggy Jean Rogers15. Birthplace Texas, El Paso16. Informant Father and motherAddress 419 New Jersey Ave S.E. Apt 5717. Burial (Burial, cremation, or removal, Which?) Date thereof 5/31/46
(month) (day) (year)Cemetery or crematory St. LucianLocation Wash. D.C.18. Funeral director Wm. Chambers &Address Quindale, Md.19. 5/30 19 46 Amanda Daunes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 19 46 at 8:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 to May 27 19 46
and that I last saw him alive on May 27 19 46

Immediate cause of death

Acute fulminating Toxemia

DURATION

24 hrs.Due to Acute gastroenteritis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE _____

Address 2503 Queens Chapel Rd.
Wt. Roomer, Md.

M. D. or other

Date signed 5/27/46

RECEIVED

JUN 1 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

15029

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 yrs., 6 mos., 22 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 6 yrs., 6 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1842 California St. N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war. _____ ✓

3. (a) FULL NAME

CURTIS, GEORGINA

3. (b) Social Security Number

0

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 25, 1923
 8. AGE: Years 23 Months 3 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Arlington, Virginia
 (Town, county, and state)

10. Usual occupation Student

11. Industry or business _____

FATHER 12. Name George L. Curtis

13. Birthplace Prince George's Co., Maryland

MOTHER 14. Maiden name Nettie Robinson

15. Birthplace Remington, Virginia

16. Informant Decedent

Address

17. Removal Date thereof May 29, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location to Washington, D.C.

18. Funeral director Traylor Funeral Home

Address 389 Rhode Island Ave. N.W. Wash. D.C.

19. May 29, 1946 Rowland S. Philips
 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1946 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/2 1939, to 5/29 1946
 and that I last saw him alive on 5/29 1946

Immediate cause of death pulmonary tuberculosis DURATION 6 years
96 mos.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinecone M.D. M. D. or other _____

Address Glenn Dale, Md. Date signed 5/29/46

RECEIVED
JUN 4 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 90

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George'sCity or town Forest Heights
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Forest Heights
(If outside city or town limits, write RURAL and give nearest town)Street No. 107 Huron Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Archibald Davies Sr

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Margaret Ann Davies7. Birth date of deceased (mo., day, yr.) May 1 18908. AGE: Years 56 Months Days If less than one day9. Birthplace Maesteg South Wales
(Town) county, and state)10. Usual occupation Guard11. Industry or business U. S. Government12. Name John Davies13. Birthplace South Wales14. Maiden name Rachael Powell15. Birthplace South Wales16. Informant Margaret Ann DaviesAddress 107 Huron Drive Forest Hts Md17. Burial Date thereof 5/29/46
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory North LawnLocation Bethesda Heights Rd Line18. Funeral director Chas E Chambers CoAddress 517 15th St., S.E. Wash. D.C.19. S-26-46 Thos D Griffiths
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 46 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 19 45 to May 25 19 46and that I last saw him alive on May 24 19 46Immediate cause of death Cardiac DURATIONasthma

Due to

Due to

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Stuartman MD M. D. or otherAddress 2015 Nichols Dr Date signed 5/25/46

RECEIVED

MAY 31 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bto*

CERTIFICATE OF DEATH

05031
 ★ Reg. Dist. No. *245*

1. PLACE OF DEATH:

County *Prince George's*City or town *Melrose*
 (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *3 months*Hospital, institution, or street address where death occurred:
110 47th Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Prince George's*City or town *Hyattsville*
 (If outside city or town limits, write RURAL and give nearest town)Street No. *4906 46 Ave*
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sherman Davis Davis

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *Colored* 6. (a) Single, married, widowed, or divorced *Married*6.(b) Name of husband or wife *Grace Davis*6.(c) If alive, give age *40* years7. Birth date of deceased (mo., day, yr.) *April 1, 1910*8. AGE: Years *36* Months *1* Days *18* If less than one day
 hrs. min.9. Birthplace *Florida*
 (Town, county, and state)10. Usual occupation *Automobile mechanic*
Own

11. Industry or business

12. Name *Walter Davis*13. Birthplace *Florida*14. Maiden name *Unknown*15. Birthplace *Florida*16. Informant *Grace Davis*Address *4906 46 Ave. Hyattsville Md.*17. *Burial* Date thereof *May 23, 1946*
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Methodist Cemetery*Location *Bladensburg Md*18. Funeral director *F. Casch Sons*Address *Hyattsville Md.*19. *May 20, 1946* Registrar *James Serry*
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 19 1946* 7:15A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19 to 19

and that I last saw him alive on 19

Immediate cause of death

*Acute congestive heart failure*Due to *Cardiovascular renal disease*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE *James D. Fox* M. D. or otherAddress *Forestville Md* Date signed *5-20-46*

1946

UNITED STATES DEPARTMENT OF AGRICULTURE

RECEIVED

MAY 22 1946

BUREAU V.S.

ARTESIAN WELLS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of usual residence of deceased is shown on
FILM No. I O 4 MAY 10 1946

MARYLAND STATE DEPARTMENT OF HEALTH
 2411 N. Charles St., Baltimore (a)

CERTIFICATE OF DEATH

05032 231
 Reg. Dist. No.

1. PLACE OF DEATH *Geo.*
 County *Pr.*
 City or town *Chesley*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *12 days*
 Hospital, institution or street address where death occurred:
Pr. Geo. Hoap.
 How long in hospital or institution? *12 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *D.C.* County _____
 City or town *Washington, 20.*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *2902 P St. S.E.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Nora Deakins

3. (b) Social Security Number

4. Sex *F* 5. Color or race *w* 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) *May 5 1870* 6. (c) If alive, give age _____ years

8. AGE: Years *75* Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace *md.* (Town, county, and state)

10. Usual occupation *Homemaker*

11. Industry or business _____

FATHER 12. Name *Lansbury,*

13. Birthplace *md.*

MOTHER 14. Maiden name *Webster,*

15. Birthplace *md.*

16. Informant *Mr. Maurice Deakins*

Address *2902 P St. S.E.*

17. *Cremation* Date thereof *5-6-1946*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Eden Hill*

Location *Suitland, Md.*

18. Funeral director *W.W. Chambers Co.*

Address *517 11th St. S.E.*

19. *5/3* 46 *Amanda Dourney*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *5-2* 19 *46* at *5:40* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *April 21, 1946* to *May 2, 1946*
 and that I last saw him alive on *May 1, 1946*

Immediate cause of death *acute perforated peptic ulcer*
 Due to *Cardiac failure*

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *R. Apple*
 _____ M. D. or other
 _____ Date signed *May 2/46*

RECEIVED

MAY 4 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (370)

CERTIFICATE OF DEATH

Reg. Dist. No. 1512842

1. PLACE OF DEATH:

County Prince Georges
City or town Sethland
(If outside city or town limits, write RURAL and give nearest town)
Now long in above place of death? 3 years
Hospital, institution, or street address where death occurred
80 Randall Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Sethland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 80 Randall Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Helen Ellison

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Edward Ellison
7. Birth date of deceased (mo., day, yr.) Jan 16 1861 8.(c) If alive, give age _____ years
8. AGE: 85 Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
12. Name Henry Trigger
13. Birthplace Virginia
14. Maiden name Ellen ~~Ellison~~ Ward
15. Birthplace Virginia

16. Informant Ruth L. Allen
Address 289-East Park
Fallon, Nevada
17. Removal Date thereof MAY 14 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____
Location Washington, D.C.
W.W. Chambers Co.
18. Funeral director
Address 517-1112 St. S.E.

19. May 14 1946 Thos S. Giffels
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1946 at 10:45 A
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1946 to May 14 1946
and that I last saw him/her alive on May 13 1946

Immediate cause of death uremia
Due to Cardiovascular
renal disease
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of Injury _____ Injured at work?

23. SIGNATURE James D. Boyd M. D. or other
Address Frederick Md Date signed 5-14-46

MARGIN RESERVED FOR BINDING

9.45.106

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 18 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

Reg. Dist. No. 05034 243

1. PLACE OF DEATH:

County Prince GeorgesCity or town Glenn Dale - RURAL
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 34 days

Hospital, institution, or street address where death occurred:

Glenn Dale SanatoriumHow long in hospital or institution? 34 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____City or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 3407- Sherman Ave., N.W.
(If rural, give LOCATION)2.(a) If veteran, name war _____ ☒

3. (a) FULL NAME

FRED DOOLIN

3. (b) Social Security Number

-

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

M6. (b) Name of husband or wife Mary Doolin

7. Birth date of

deceased (mo., day, yr.)

Sept. 12, 18906. (c) If alive, give age 43 years

8. AGE:

Years

Months

Days

If less than one day

55720

hrs.

min.

9. Birthplace Center, Missouri

(Town, county, and state)

10. Usual occupation Cook11. Industry or business -

FATHER

12. Name

Richard Doolin

13. Birthplace

Center, Mo.

MOTHER

14. Maiden name

Elizabeth Turley

15. Birthplace

Center, Mo.

16. Informant

deceased

Address

17.

Removal to
(Burial, cremation, or removal. Which?)

Date thereof

May 2, 1946
(month) (day) (year)

Cemetery or crematory

Location

Washington D.C. -

18. Funeral director

Robert H. McQuire

Address

1820 9th St. N.W.

19.

May 2, 1946
(Date rec'd by registrar)Roelandt S. Phillips
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2 1946, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-29 1946, to 5-2 1946
and that I last saw him alive on 5-2 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

3 months

Due to

Due to

Other conditions

Haemorrhoids

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Finucane M.D.

M. D. or other

Address

Glenn Dale, Md.

Date signed

5/2/46

RECEIVED

MAY 7 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County PRINCE GEORGE
 City or town BERWYN MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 MONTH 14 DAYS
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County PRINCE GEORGE
 City or town BERWYN
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4815 RUATAN STREET
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

IDA LEVI FINNELL

3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

CLARK E

7. Birth date of

deceased (mo., day, yr.)

DEC. 4, 1868

8. AGE:

Years

Months

Days

if less than one day

77

hrs.

min.

9. Birthplace

FAIRVIEW, VIRGINIA

(Town, county, and state)

10. Usual occupation

RETIRED

11. Industry or business

HECHT COMPANY

FATHER

12. Name

GEORGE W. LEVI

13. Birthplace

RICHFIELD, VIRGINIA

MOTHER

14. Maiden name

SARAH HORTON

15. Birthplace

WEEDSPORT, N.Y.

16. Informant

MRS. T. RAYMOND BURCH

Address

4815 RUATAN ST. BERWYN, MD.

17.

BERRYVILLE VA.

Date thereof

5 3 1946

(Burial, cremation, or other)

(month) (day) (year)

Cemetery or crematory

GREENHILL

Location

BERRYVILLE VA.

18. Funeral director

P. J. Farrell

Address

475 A-M N.W. Wash. D.C.

(Date rec'd by registrar)

19.

James Levey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 3

19.

46at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

19.

and that I last saw him alive on

19.

Immediate cause of death

DURATION

Acute congestive heart failure
Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

deputy medical examiner
James J. Farrell

23. SIGNATURE

M.D. or other

Address

Forester
5-3-46

Date signed

RECEIVED

MAY 5 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05036

Reg. Dist. No. 232

1. PLACE OF DEATH:

County Prince George's

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yr

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elmore Freeland

3. (b) Social Security Number

4. Sex Female

5. Color or race Colored

6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife George Freeland

6. (c) If alive, give age died years

7. Birth date of deceased (mo., day, yr.) May 18 1881

8. AGE: Years 65 Months 0 Days 4 If less than one day hrs. min.

9. Birthplace Croome, Md

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same

12. Name Sam Jackson

13. Birthplace Maryland

14. Maiden name Elizabeth Jackson

15. Birthplace Croome, Md

16. Informant John H Wedge

Address Upper Marlboro, Md

17. Burial (Burial, cremation, or removal. Which?) Data thereof May 25/46

Cemetery or crematory Union Cemetery

Location Upper Marlboro

18. Funeral director J.B. Finner

Address Annapolis

19. May 25 46 Registrar

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1946 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1940 to May 22 1946

and that I last saw her alive on May 21 1946

Immediate cause of death Cerebral Hemorrhage

DURATION 2 hrs

Due to Nephritis

10 yr

Due to

Other conditions Arteriosclerosis

12 yr

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. 7

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reverdy Lasswell

M. D. or other

Address Upper Marlboro Date signed 8/23

RECEIVED
MAY 25 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05037 239

1. PLACE OF DEATH:

County Prince Geo.City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince GeorgeCity or town Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 36 A. St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alice Pearl Friskey

3. (b) Social Security Number

4. Sex

Female

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife George W. Friskey

7. Birth date of

deceased (mo., day, yr.)

July 23 1858

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

if less than one day

8792

..... hrs. min.

9. Birthplace Hartford Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Isaac E. Willie

13. Birthplace

Md.

14. Maiden name

Martha Cummings

15. Birthplace

Md.

16. Informant

Harry W. FriskeyAddress 36 A. St. Laurel, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 28. 1946

(month) (day) (year)

Cemetery or crematory

Ivy Hill

Location

Laurel, Md.

18. Funeral director

DeWitt Donaldson

Address

Laurel, Md.

19.

(Date rec'd by registrar)

19.

46 M. Brashers
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22-1946 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-4-46 to 5-22-1946and that I last saw him alive on 5-24-1946Immediate cause of death Acute Coronarydegeneration

DURATION

1 d.

Due to

Myocardial

Due to

myocardial

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. W. W. Warr
Laurel, Md.

M. D. or other

Address

Date signed 5-28-46

RECEIVED

JUN 2 1946

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

FILM No. I O 4 MAY 22 1946

Reg. Dist. No. 05038 231

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred? Selander Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Bladensburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4909- Upshur Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Fannie Ganderbert

3.(b) Social Security Number

4. Sex Female

5. Color or race Colored

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 17 1886-

8. AGE: Years 60 Months 59 Days 59 If less than one day hrs. min.

9. Birthplace Ind. :-
(Town, county, and state)

10. Usual occupation servant

11. Industry or business House work.

12. Name unknown

13. Birthplace sophia snell

14. Maiden name Ind.

15. Birthplace Ind.

16. Informant Walter Barnes

Address Riverdale Ind

17. (Burial, cremation, or removal. Which) Burial Date thereof May 9, 1946
(month)(day)(year)

Cemetery or crematory Methodist Cemetery

Location Bladensburg Ind

E. Gasco's sons

18. Funeral director Bladensburg Ind.

Address

19. May 9th 46 Amanda Brown

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 6 19 46 at 7:24 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h. alive on 19

Immediate cause of death acute congestive heart failure

Due to cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statitically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Deputy Medical Examiner

23. SIGNATURE James D. Lord M. D. or other

Address Frestville Ind Date signed 5-7-46

RECEIVED
MAY 11 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05039

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____

City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 524 Kenyon St. N. W.
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

JOSEPH GOODWIN

3. (b) Social Security Number

4. Sex M 5. Color or race Col 6. (a) Single, married, widowed, or divorcedSingle

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) July 28, 1909
 6. (c) If alive, give age _____ years

8. AGE: Years 36 Months 10 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Charleston, South Carolina
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Eli Goodwin13. Birthplace Richland Co., S. Carolina14. Maiden name Lillian Adams15. Birthplace Richland Co., South Carolina16. Informant Decedent

Address _____

17. Removal Date thereof 5-25-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory RemovalLocation Washington D. C.18. Funeral director W. E. Davis Co.Address 1432 7th St. N. W. Wash. D. C.

19. May 23 1946 Rowland & Phillips
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 46 at 10:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 16 19 46 to May 25 19 46

and that I last saw him alive on May 25 19 46

Immediate cause of death Pulmonary Tuberculosis
 DURATION 4 months

Due to _____

Due to _____

Other conditions Tuberculous Laryngitis 3 weeks

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinecone MD M. D. or otherAddress Glenn Dale, Md. Date signed 5/25/46

RECEIVED

MAY 31 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

05040

★ Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges
 City or town Forestville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

7600 Marlboro Pike SE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges

City or town Forestville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 7600 Marlboro Pike
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Everett Fendall Gray

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white single

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 29, 1920
 8.(c) If alive, give age _____ years

8. AGE: Years 25 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Forestville Md
 (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business

12. Name Fendall Gray
 13. Birthplace Maryland
 14. Maiden name Grace Lee Humphrey
 15. Birthplace Forestville, Maryland

16. Informant Fendall Gray
 Address 7600 Marlboro Pike SE

17. Burial Date thereof May 25, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Epiphany Cemetery
 Location Forestville Md
W W Chambers Co.

18. Funeral director

Address 517-11th St. SE. Washington D.C.

19. May 22 46 W W Chambers Co.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 19 46 at 1:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19 41 to May 22 19 46
 and that I last saw him alive on May 19 19 46

Immediate cause of death

Exhaustion
Toxemia
Tuberculosis Pulmonary
Diabetes
Ulcerative colitis

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James D. Ford M. D. or other
 Address Forestville Md Date signed 5-22-46

RECEIVED
MAY 25 1946
BUREAU OF

Evidence for addition of
place of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 237

FILM No. 106 AUG 2, 1946

1. PLACE OF DEATH:

County PRINCE GEORGE'S

City or town Aquasco
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County P.G.

City or town Poplar Hill Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARY FRANCES GRAY

3. (b) Social Security Number

4. Sex Female 5. Color or race colored 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Samuel Hall

7. Birth date of deceased (mo., day, yr.) 1872 6.(c) If alive, give age years

8. AGE: Years 74 Months Days If less than one day hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Samuel Hall

13. Birthplace Md

14. Maiden name Margaret Hardy

15. Birthplace Md

16. Informant Clarence Gray

Address Bagdad, Md

17. Burial Date thereof (month) (day) (year)

Cemetery or crematory St. Thomas Cemetery

Location Poplar Hill

18. Funeral director Huntly Kyrn

Address Waldorf Md

19. May 27th 1946 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 25 1946 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 19 1946 to MAY 19 1946 and that I last saw her alive on MAY 19 1946

Immediate cause of death HEART FAILURE DURATION

Due to CARDIAC DECOMPENSATION

Due to CARDIO VASCULAR RENAL DISEASE

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Alfred R. Lapin, M.D.

Address Aquasco, Md Date signed 27 May 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 5 1946

BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

CERTIFICATE OF DEATH

05042

Reg. Dist. No. 232

1. PLACE OF DEATH:

County Prince Georges

City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

3. (a) FULL NAME

Joseph Samuel Gross

4. Sex

male

5. Color or race

Caucasian

6. (a) Single, married, widowed, or divorced

Separated

6. (b) Name of husband or wife Margaret Gross

7. Birth date of

deceased (mo., day, yr.) May 11, 1911

8. AGE:

Years 35 Months 0 Days 1 If less than one day

9. Birthplace

Maryland (Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Farmer

FATHER

12. Name Augustus Edward Gross

13. Birthplace Maryland

14. Maiden name Fannie Purnell

15. Birthplace Maryland

16. Informant Sam Fannie Gross

Address Brandysville, Va.

17. Burial Date thereof 5 14 46

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Gibbons Chapel

Location Brandysville Rd

18. Funeral director Ritchie Bros

Address Upper Marlboro Rd

May 13 46 Registrar

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1946 at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death Hemorrhage and shock

Due to Gun shot wound of chest and abdomen

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date 5-12-46

Where did injury occur? Upper Marlboro Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Shot with state

Injured at work? Deputy medical examiner

23. SIGNATURE James J. Taylor

Address Forestville Md Date signed 5-12-46

MAY 14 1946

BUREAU V.L.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Md. - RURAL
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 months, 18 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 11 months, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4723- Wash. Pl., N.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

CALVIN LEE HARGROVE

3. (b) Social Security Number

225-05-3246

4. Sex <u>male</u>	5. Color or race <u>col.</u>	6. (a) Single, married, widowed, or divorced <u>married</u>	
6. (b) Name of husband or wife <u>Alfreda Hargrove</u>			
6. (c) If alive, give age <u>52</u> years			
7. Birth date of deceased (mo., day, yr.) <u>March 20, 1889</u>			
8. AGE:	Years <u>57</u>	Months <u>2</u>	Days <u>2</u> If less than one dayhrs.min.
9. Birthplace <u>Henderson, N. Carolina</u> (Town, county, and state)			
10. Usual occupation <u>Mover for Govt.</u>			
11. Industry or business _____			
FATHER	12. Name <u>Azule Hargrove</u>		
	13. Birthplace <u>Henderson, N. Car.</u>		
MOTHER	14. Maiden name <u>Caroline Malone</u>		
	15. Birthplace <u>Henderson, N. Car.</u>		

16. Informant <u>decendent</u>
Address _____
17. <u>Removal</u> (Burial, cremation, or removal. Which?)
Date thereof <u>May 22, 1946</u> (month) (day) (year)
Cemetery or crematory _____
Location <u>to Washington, D.C.</u>
18. Funeral director <u>W. Ernest Jarvis &</u>
Address <u>1432 You St. N.W. Wash. D.C.</u>
19. <u>May 23, 1946</u> (Date rec'd by registrar)
<u>Rowland J. Phillips</u> Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH <u>May 22, 1946</u> at <u>3:15 A.M.</u>	
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>June 4, 1945</u> to <u>May 22, 1946</u> and that I last saw him alive on <u>May 21, 1946</u>	
Immediate cause of death <u>Pulmonary Tuberculosis</u>	DURATION <u>1 yr.</u>
Other conditions <u>Tuberculous enteritis</u> (Include pregnancy within 3 months of death)	<u>2 days</u>
Major findings of operations _____	Date of op. _____
Autopsy results _____	PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:		
Accident, suicide, or homicide _____	Date of _____	
Where did injury occur? _____	(City or town)	(County) (State)
Injured at home, farm, industry, public place (where?) _____		
Means of Injury _____	Injured at work? _____	
23. SIGNATURE <u>Daniel Leo Pinecone M.D.</u> M. D. or other _____		
Address <u>Glenn Dale, Md.</u>	Date signed <u>5/22/46</u>	

63-107

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

RECEIVED
MAY 31 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 994

CERTIFICATE OF DEATH

FILM No. I O 4 MAY 29 1946

05044

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Allen Prince George'sCity or town Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Prince George'sCity or town Seatonsville, Prince Georges Co
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Rufus Harris

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct 14 1881

6. (c) If alive, give age _____ years

8. AGE:

Years 64 Months 65 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace

North Carolina
(Town, county, and state)

10. Usual occupation

Cook

11. Industry or business

Preston Harris

12. Name

North Carolina

13. Birthplace

May Steele

14. Maiden name

North Carolina

15. Birthplace

James Sweetney

16. Informant

Adelwick Ave + m. Blair

Address

BurialDate thereof May 29, 1946
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Woodlawn Cem.Location 4411 Benning Rd. S.E. Wash. D.C.Malva + 180 Key Ave4445 Dean Ave N.E.5/261946Carrie F. Campbell5/261946Carrie F. Campbell5/261946Carrie F. Campbell

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1946 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 1946 to May 25 1946and that I last saw him alive on May 25 1946

Immediate cause of death

Hypertension

Due to

Hypertensive Heart Disease

Due to

Cerebral Hemorrhage?

Other conditions

Debility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

H. G. Beeson4423 - Hunt PLME 5-25-46

Address _____ Date signed _____

RECEIVED

MAY 25 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05045 243
Reg. Diat. No.

1. PLACE OF DEATH:

County Prince Georges
City or town Glenn Dale, Md. - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 4 mo.s., 3 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 4 mo.s., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D.C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1408- Hopkins St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

CLARENCE O. HARRISON

3. (b) Social Security Number

237-05-8092

4. Sex

male

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Lilly Harrison

7. Birth date of

deceased (mo., day, yr.)

April 23, 19176. (c) If alive, give age 29 years

8. AGE:

Years

Months

Days

If less than one day

29-21

.....hrs.min.

9. Birthplace Nash Co., N. Carolina

(town, county, and state)

10. Usual occupation valet service

11. Industry or business

FATHER
MOTHER12. Name William B. Harrison13. Birthplace Nash Co., N. Car.14. Maiden name Fanny Ethridge15. Birthplace Nash Co., N. Car.16. Informant deceased

Address

17. Removal
(Burial, cremation, or removal. Which?)Date thereof May 15, 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1946 at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 17 1946 to May 14 1946
and that I last saw him alive on May 14 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pincone M.D.
Address Glenn Dale, Md. Date signed 5/14/46

RECEIVED
MAY 24 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 102

CERTIFICATE OF DEATH

05046

★ Reg. Dist. No. 245

1. PLACE OF DEATH:

County 4504 Church St. Brentwood MdCity or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Marie A. Hawkins

4. Sex

Female

5. Color or race

Red

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

John U. M. Hawkins

7. Birth date of

deceased (mo., day, yr.)

Feb 28 1882

6. (c) If alive, give age

66 years

8. AGE:

Years 64

Months

Days

If less than one day

hrs. min.

9. Birthplace

Washington D.C.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

James Dyer

13. Birthplace

U.S.A.

14. Maiden name

Elizabeth Jackson

15. Birthplace

U.S.A.

16. Informant

Betha BerkleyAddress 4504 Church St. Brentwood Md17. Burial Date thereof May 19 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director

John L. StewartAddress 36 H. St. N.W. Wash. D.C.May 19 46 James Berry Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State 4504 Church St. MarylandCity or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)Street No. 4504 Church St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19-46 at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-18-45 to 5-17-46and that I last saw him alive on 3-18-46Immediate cause of death HypertensionDURATION 3 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. C. Oliver Jr. D.Address 1901-11th Ave Date signed 5-19-46

RECEIVED

MAY 21 1966

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for the change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05047

FILM NO. I O 4 JUN 11 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH: Prince George
County.....
City or town..... Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
Laurel Sanit.
How long in hospital or institution? 34 hr.; 3 M.; 25 P

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Maryland
State..... Maryland County..... Montgomery
City or town..... Upper Rooma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 110 Maple Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
George Frank Hedgcock

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Della Marshall Hedgcock

7. Birth date of deceased (mo., day, yr.) October 5 - 1865 3 8. (c) If alive, give age..... years

8. AGE: Years 82 Months 40 Days 7 If less than one day 6 hrs. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual occupation Plant Pathologist

11. Industry or business U. S. Government Ag. Dept

12. Name Barnett Hedgcock

13. Birthplace Illinois

14. Maiden name Lucretia Haines

15. Birthplace Illinois

16. Informant Sanitarium Record

Address Laurel Sanitarium, Laurel, Maryland

17. Burial (Burial, cremation, or other, Which) Date thereof May 14, 1946 (month) (day) (year)

Cemetery or crematory Mt. Lincoln Cemetery

Location Mt. Lincoln Cemetery

18. Funeral Director Dr. J. H. Stollers

Address 254 Carroll St., Takoma Park, D.C.

May 11 1946 M. Brashers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1946 at 6:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16 1943 to May 11 1946 and that I last saw him alive on May 11 - 1946

Immediate cause of death Cardiac Decompen sation

Due to Mitral Regurgitation

Due to Senility

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John L. Wethered

Address Laurel San. Md. Date signed 5/11/46

RECEIVED
MAY 14 1946
BUREAU V L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

05048

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's

City or town Bowie
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: _____

Stay in hospital or inst. (yrs., or mos., or days) _____

Stay in this community (yrs., or mos., or days) 55 yr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pr. George's

City or town Bowie Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)

Street No. _____
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Mr. Italian Heilig

3. (b) Social Security Number

019-16-1961

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Teressa Heilig

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Jan. 27th 1868

8. AGE: Years 83 Months 3 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Baden, Germany
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Joseph Heilig

13. Birthplace Germany

MOTHER 14. Maiden name Magdalena Zoffler

15. Birthplace Germany

16. Informant Leona Heilig (daughter)

Address Bowie, Md.

17. Burial Date thereof May 15 - 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ascension

Location Bowie Md

18. Funeral director Morton Heilig, Sons

Address Bowie Md

19. May 15 1946 Wm. J. W. Giegling
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1946, at 11:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 22 1943, to May 12 1946, and that I last saw him alive on May 12 1946.

Immediate cause of death

Chronic Myocarditis

DURATION

6 mo.

Due to Coronary atherosclerosis

2 1/2 yrs

Due to Chronic Hypertension

6 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Df operations _____

Of autopsy _____

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert J. McConney M.D.

Address Laurel Md Date signed 5/13/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 18 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05049

242

1. PLACE OF DEATH:

County Prince GeorgeCity or town Silver Hill, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo.City or town Silver Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4560 St. Barnabas Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

AUGUSTA SARAH HEINEMEYER

3.(b) Social Security Number

--

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

WidowedB.(b) Name of husband or wife August

7. Birth date of

deceased (mo., day, yr.) January 25, 1864

6.(c) If alive, give age -- years

8. AGE: Years Months Days If less than one day

82 3 17 hrs. min.9. Birthplace Philadelphia

(Town, county, and state)

10. Usual occupation --11. Industry or business --12. Name August Heinemeyer13. Birthplace Hamburg, Germany14. Maiden name Sarah Wassmer15. Birthplace Germany16. Informant Mrs. J.C.PylesAddress 806 D St., S.E. Wash. 3, D.C.17. Burial Date thereof May 15, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Barnabas Ch. CemeteryLocation Oxen Hill, Maryland18. Funeral director James Hagan, Inc.Address 317 Penna. Ave., S.E. Wash. 3, D.C.5-12 46 Thos J. Suffolk

19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 19 46 at 8:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 15 19 46 to May 12 19 46and that I last saw alive on May 11 19 46

Immediate cause of death

Heart failureDue to Chronic NephritisOther conditions Acute Gastroenteritis

DURATION

2 mo.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles Pyles

M. D. or other

Address 406 22nd St. Date signed 5/12/46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
MAY 18 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County.....Prince George's
 City or town.....(rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos., 29 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 2 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....D.C. County.....
 City or town.....Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....544- 23rd St. N. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Luke Otis Holloway

3. (b) Social Security Number

-

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ethel Holloway

6. (c) If alive, give age 27 years

7. Birth date of

deceased (mo., day, yr.)

May 20, 1910

8. AGE:

Years

Months

Days

If less than one day

36

-

9

hrs.

min.

9. Birthplace

Edgefield, South Carolina

(Town, county, and state)

10. Usual occupation

Naval Research Lab.

11. Industry or business

FATHER
MOTHER

12. Name

Luke Holloway

13. Birthplace

Edgefield, South Carolina

14. Maiden name

Rosie Holloway

15. Birthplace

Edgefield, South Carolina

16. Informant

Decadent

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof May 29, 1946

Cemetery or crematory

Location

18. Funeral director

Malvan & Schey, Inc.

Address

4445 Deane Ave. NE Wash. D.C.

19. May 29, 1946

(Date rec'd by registrar)

Rowland of Philips

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 29, 1946 at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 30, 1945, to May 29, 1946

and that I last saw him alive on May 29, 1946

Immediate cause of death

Pulmonary tuberculosis 2 yrs 8 mo

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinckard M.D.

M. D. or other

Address

Glenn Dale, Md.

Date signed 5/29/46

RECEIVED
JUN 4 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges
City or town Glenn Dale, Md. - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs - 6 mo. s. 4 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? same

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 417- 5th, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

RANDOLPH D. HOLMES

3. (b) Social Security Number
579-09-1716

4. Sex male 5. Color or race col. 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Blanche Holmes

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1898 6.(c) If alive, give age 46 years

8. AGE: Years 48 Months 2 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation truck driver

11. Industry or business -

12. Name Jessie Holmes

13. Birthplace Wash., D.C.

14. Maiden name Maggie Morton

15. Birthplace Chancellor, Va.

16. Informant deceased

Address _____

17. Removed to Date thereof May 13, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory _____

Location Washington, D.C.

18. Funeral director Malban + Schey

Address 424 R. St. N.W. Wash. D.C.

19. May 12 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1946 at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 8, 1943 to May 12, 1946 and that I last saw him alive on May 12, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 4 yrs 4 1/2 mo.

Due to _____

Due to _____

Other conditions Tuberculosis Laryngitis 7 mo.
The stenosis of R.U.L. bronchus 1 yr 7 mo.
(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Finucane M.D.
M. D. or other _____

Address Glenn Dale Md Date signed 5/12/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REC

MAY 24 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

05052

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
City or town (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 12 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1427 - 9th St. N. W.
(If rural, give LOCATION)
2. (a) If veteran, name war _____ ✓

3. (a) FULL NAME

ELSINER. HUNTER.

3. (b) Social Security Number

?

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Fannie Bell Hunter

6. (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) February 14, 1917

8. AGE: Years 29 Months 3 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Wellford, South Carolina
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Pennsylvania Railroad

12. Name Elsiner Hunter

13. Birthplace South Carolina

14. Maiden name Carrie Rogers

15. Birthplace South Carolina

16. Informant Decedent

Address _____

17. Removal Date thereof May 31, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location to Washington, D. C.

18. Funeral director McGuire Funeral Service

Address 1820 - 9th St. N.W. Washington, D. C.

19. May 31, 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1946 at 10:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1946 to May 31, 1946 and that I last saw him alive on May 31, 1946

Immediate cause of death _____ DURATION 7 yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane M.D.
M. D. or other _____

Address Glenn Dale, Md. Date signed 5/31/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 11 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

05053

Reg. Dist. No. 245

1. PLACE OF DEATH:

County.....

City or town.....

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

. 64

hrs.

min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 6

19. 46

at 4²⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 12

19. 46

to May 6

19. 46

and that I last saw him alive on

May 6

19. 46

Immediate cause of death.....

Arteriosclerotic Heart Disease

DURATION

5 years

Due to.....

Due to.....

Other conditions.....

Generalized arteriosclerosis
Cerebral Sclerosis

(Include pregnancy within 8 months of death)

5 years
1 year

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. van Kinsbergen, M.D.

M. D. or other

Address.....

29 Grand Circle, N.W., Wash. D.C.

Date signed.....

May 6, 1946.

sh

4640-1



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

05054

Reg. Dist. No.

239

1. PLACE OF DEATH:

County... Prince George's

City or town... Laurel
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... transient

Hospital, institution, or street address where death occurred:...

Montgomery Road

How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Burtonsville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war... 140

3. (a) FULL NAME

Carroll Murdoch Iglehart

3. (b) Social Security Number

NONE.

4. Sex... male

5. Color or race... white

6. (a) Single, married, widowed, or divorced... married

6. (b) Name of husband or wife... Rossie E. Iglehart

6. (c) If alive, give age... 48 years

7. Birth date of deceased (mo., day, yr.)... Oct 3, 1898

8. AGE: Years... 47 Months... 7 Days... 10 hrs. min.

9. Birthplace... Maryland
(Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business

12. Name... Edwin A. Iglehart

13. Birthplace... Maryland

14. Maiden name... Bessie E. Soper

15. Birthplace... Maryland

16. Informant... Mrs. Rossie E. Iglehart

Address... Burtonsville, Md

17. Burial (Burial, cremation, or removal. Which?)... Burial Date thereof... May 15 1946
(month) (day) (year)

Cemetery or crematory... Burtonsville Union

Location... Burtonsville - Montg Co. Md

18. Funeral director... Warner E. Pumphrey

Address... 8434 Ga Ave. Silver Spring - Md.

May 16 1946 M. Brashear
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 13 1946 at 1:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from... 19... to... 19...

and that I last saw him... alive on... 19...

Immediate cause of death...

Acute pulmonary edema
acute congestive heart failure
Cardiorenal disease

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury... Injured at work?

Deputy medical examiner

23. SIGNATURE... M. D. or other

Address... Forestville, Md Date signed... 5/13/46

RECEIVED
MAY 18 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05055

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince GeorgesCity or town Glenn Dale, Md. - Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 28 daysHospital, institution, or street address where death occurred:
Glenn Dale SanatoriumHow long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 628- N. St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Leroy Jackson

3. (b) Social Security Number

578-20-8507

4. Sex

male

5. Color or race

col

6. (a) Single, married, widowed, or divorced

marriedB. (b) Name of husband or wife Maggie R. Jackson7. Birth date of deceased (mo., day, yr.) July 11, 1909
6. (c) If alive, give age 36 years8. AGE: Years 36 Months 10 Days 6 If less than one day
hrs. min.9. Birthplace Washington, D. C.
(Town, county, and state)10. Usual occupation Cook

11. Industry or business

12. Name John Jackson13. Birthplace Lexington, Ky.14. Maiden name Esther Bolden15. Birthplace Farmville, Virginia16. Informant deceased

Address

17. Removal to Date thereof May 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington, D.C.18. Funeral director Wm. T. TalbertAddress 1308-6th St., N.W., Wash. D.C.19. May 17, 1946 Rowland S. Philips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1946 at 4³⁰ A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 19, 1946 to May 17, 1946
and that I last saw him alive on May 17, 1946Immediate cause of death
Pulmonary Tuberculosis
Tuberculous Laryngitis

DURATION

4 Mo4 Wks

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucane M.D.
M. D. or otherAddress Glenn Dale Md Date signed 5/17/46

RECEIVED

MAY 31 1946

BUREAU V 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Md. RURAL
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 16 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 2 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1342- 5th, N.W.
 (If rural, give LOCATION)
 2(a) If veteran, name war no ✓

3. (a) FULL NAME

LILLIE MAE JONES

3. (b) Social Security Number

-

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife John Henry Jones
 6. (c) If alive, give age dec. years
 7. Birth date of deceased (mo., day, yr.) June 9, 1909
 8. AGE: Years 36 Months 10 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Seneca, South Carolina
 (Town, county, and state)
 10. Usual occupation housewife
 11. Industry or business -

FATHER 12. Name Richard Marshall
 13. Birthplace Seneca, South Carolina
 MOTHER 14. Maiden name Ada Ellington
 15. Birthplace Seneca, South Carolina

16. Informant deceased
 Address _____

17. removal Date thereof May 2, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory _____

Location 26 Edgely
 18. Funeral director Hall Bros.
 Address 631 Fla Ave N.W. D.C.

19. May 2 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 2 19 46 at 4:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 - 15 19 46, to 5 - 2 19 46, and that I last saw him in alive on 5 - 2 19 46.

Immediate cause of death Pulmonary Tuberculosis DURATION 3 mos

Due to _____
 Due to _____

Other conditions Syphilis
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane MD M. D. or other _____
Glenn Dale, Md. Address _____ Date signed 5/2/46

RECEIVED

MAY 7 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B.E.)

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Md. - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months - 2 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 2 months - 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 507- M. St. S. N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3.(a) FULL NAME

WILLIAM JONES

3.(b) Social Security Number

4. Sex male 5. Color or race col 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Mary Mills Jones
 6.(c) If alive, give age 24 years
 7. Birth date of deceased (mo., day, yr.) October 1, 1912
 8. AGE: Years 33 Months 7 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Jacksonville, Florida
 (Town, county, and state)
 10. Usual occupation Laborer in Govt. Dept.
 11. Industry or business _____
 FATHER
 12. Name Robert Jones
 13. Birthplace ? , So Carolina
 MOTHER
 14. Maiden name Rivine Stevens
 15. Birthplace ? So Carolina

16. Informant decedent
 Address _____
 17. Removal Date thereof May 21, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory _____
 Location to Washington, D.C.
 18. Funeral director John J. Rhines
 Address 901 - 3rd St. S.W.
 19. May 21, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21st 19 46 at 2 A 45 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9th 19 46 to May 21st 19 46
 and that I last saw him alive on May 21st 19 46

Immediate cause of death _____
Pneumonia & Tuberculosis
 Due to _____
 Due to _____
 Other conditions _____

DURATION

2 yrs 2 mo

(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____
 Autopsy results Tuberculosis of mentum and intestines
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane M.D.
 M. D. or other _____
 Address Glenn Dale, Md Date signed 5/21/46

RECEIVED
MAY 31 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *718*

05059

CERTIFICATE OF DEATH

★ Reg. Dist. No. *223*

1. PLACE OF DEATH:

County *Prince George*City or town *TAKOMA PARK*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *8 mos.*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD.* County *CB.*City or town *Takoma Park*
(If outside city or town limits, write RURAL and give nearest town)Street No. *410 Ethan Allen Ave*
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

OTTO JORG

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *July 13 - 1872*8. AGE: Years *73* Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace *Washington, D.C.*
(Town, county, and state)10. Usual occupation *salesman*11. Industry or business *Bakery*12. Name *Henry Jorg*13. Birthplace *Germany*14. Maiden name *Anna Elizabeth Schmidt*15. Birthplace *Germany*16. Informant *William Jorg*Address *178-UNLAD TERR. N.E.*17. *Burial* (Burial, cremation, or removal. Which?) Date thereof *5-31-46*
(month) (day) (year)Cemetery or crematory *Prospect Hill*Location *Washington, D.C.*18. Funeral director *Joseph Sawter Bros*Address *4756 - Upton Ave.*19. *May 29* 19 *46* Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 28th* 19 *46* at *6:30* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *October 1st* 19 *40* to *May 27* 19 *46*and that I last saw him alive on *May 27th* 19 *46*Immediate cause of death *Malignant**metastasis of lungs**+ bones*Due to *carcinoma of pros-**tate gland*

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *J. C. Minkoff*Address *1801 E. Ave St. NW* M. D. or other *5/28/46*Date signed *5/28/46*

RECEIVED
JUN 2 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-6

CERTIFICATE OF DEATH

05058



Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges County
 City or town Crofton, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:

Prince Georges General Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1107 29th Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

William W. Kennement

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 59 Months 7 Days 26 It less than one day
hrs.min.

9. Birthplace D.C.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name Jack W. Kennement

13. Birthplace D.C.

MOTHER 14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial Date thereof May 29, 1946
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Washington, D.C.

18. Funeral director W. W. Chambers & Co.

Address Wash. D.C.

19. 5/25 19 46 Amanda Downey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 46, at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 19 46, to May 25 19 46.

and that I last saw him alive on May 25 19 46.

Immediate cause of death Congestive heart failure

DURATION
1 week

Due to Rheumatic heart dis-
ease.

4 yrs
 (History)

Due to.....

Other conditions General arteriosclerosis (7)

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Smit Ritchie
 M. D. or other

Address 6906 Ritchie Road SE
Wash. D.C.

Date signed May 25 1946

RECEIVED

MAY 29 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19102

CERTIFICATE OF DEATH

 05060
 Reg. Dist. No. 42

1. PLACE OF DEATH:

County Prince George's
 City or town Cockeysville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 weeks
 Hospital, institution, or street address where death occurred:
7580 Walker Mill Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Cockeysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7580 Walker Mill Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Norman Littleford

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Lilly Littleford
 6.(c) If alive, give age 68 years
 7. Birth date of deceased (mo., day, yr.) November 1887
 8. AGE: Years 58 Months Days If less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business
 12. Name Lashie Littleford
 13. Birthplace Maryland
 14. Maiden name Unknown
 15. Birthplace Maryland

16. Informant Enoch Littleford
 Address 7580 Walker Mill Road
 17. Burial Date thereof 5-23-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Epiphany
 Location Fort Detrick Md.
 18. Funeral director Patricia B. B. B.
 Address Upper Marlboro, Md.

19. 5/21 19 46 Carrie F. Campbell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 46 at 4:02 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19....., 10....., 19.....
 and that I last saw him..... alive on 19.....

Immediate cause of death..... DURATION
Acute congestive heart failure
 Due to Cardiovascular renal disease
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Heepert Medical Examiner
James R. Loyd
 Address Frederick Md. Date signed 5-20-46

RECEIVED

MAY 23 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-

CERTIFICATE OF DEATH

05061 243
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George's
City or town (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 4 mos., 23 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 4 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 610 - 53rd St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

ROBERT H. MAJOR

3. (b) Social Security Number

Lost

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Frances Major
6.(c) If alive, give age 28 years
7. Birth date of deceased (mo., day, yr.) December 26, 1917
8. AGE: Years 28 Months 4 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Culpepper, Virginia
(Town, county, and state)
10. Usual occupation Steam Press Operator
11. Industry or business _____
12. Name John Major
13. Birthplace Culpepper, Virginia
14. Maiden name Emma Mason
15. Birthplace Culpepper, Virginia

16. Informant Decedent
Address _____
17. removal Date thereof May 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory _____
Location Washington, D.C.
18. Funeral director Henry S. Washington & Co.
Address 467 W. St. N.W.
19. 5/25 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 25 1946 at 8:15 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN. 2 1945 to MAY 25 1946
and that I last saw him alive on MAY 25 1946
Immediate cause of death Meningitis due to Micrococcus Tetragenous DURATION 12 days
Due to Pulmonary tuberculosis 2 yrs 5 mo.
Due to Left tuberculous empyema and broncho pleural fistula 1 yr 2 mo.
Other conditions _____
(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other _____
Address Glenn Dale, Md. Date signed 5/25/46

RECEIVED
MAY 31 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-2

CERTIFICATE OF DEATH

05062

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince GeorgesCity or town Clewerly
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 hrs. 00 min.

Hospital, institution, or street address where death occurred:

Prince Geo. Hosp.How long in hospital or institution? 10 hrs. 00 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Pr. Geo. CountyCity or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)Street No. 3716 Shepherd St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mrs. Florence McDonald

3.(b) Social Security Number

4. Sex Female5. Color or race White6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Wm. L. McDonald

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 1 - 19038. AGE: Years 42 Months _____ Days _____ It less than one day _____ hrs. _____ min.9. Birthplace va.
(Town, county, and state)10. Usual occupation h.w.

11. Industry or business

12. Name Cerey Lumpkin13. Birthplace va.14. Maiden name Mary J. Lumpkin15. Birthplace Fairfax, Va.16. Informant M. Wm. L. McDonaldAddress 3716 Shepherd St., Brentwood17. Removal Date thereof May 3, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director T.F. CostelloAddress 1722 N. Capital St. Wash., D.C.19. 5/3 19 46 Amanda Dauncey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 2 - 1946 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Cerebral CompressionDue to Subdural hemorrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE James J. Ford M. D. or otherAddress Forestville Md. Date signed 5-3-46

RECEIVED

MAY 4 1946

BUREAU

STATE OF MARYLAND—CERTIFICATE OF DEATH

05063

1. PLACE OF DEATH

County Prince Georges Registration Dist. No. 240
 Village or City Cheltenham, Md No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

(a) Residence: No. Cheltenham, Md St. _____ Ward _____
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND or (or) WIFE of Sola Middleton

6. DATE OF BIRTH (month, day, and year) Oct 26 - 1894

7. AGE Years 51 Months 6 Days 22 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farm work

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. _____

10. Date deceased last worked at this occupation (month and year) Aug 19 43 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) Nottingham (State or country) Md

13. NAME George Middleton

14. BIRTHPLACE (city or town) Poplar Hill (State or country) Md

15. MAIDEN NAME Henrietta Watson

16. BIRTHPLACE (city or town) Oxon Hill (State or country) Md

17. INFORMANT Albert Middleton (Address) Cheltenham, Md

18. BURIAL, CREMATION, OR REMOVAL Place Brown's Mt Date 5/21, 1946

19. UNDERTAKER Hunt & Ryan (Address) _____

20. FILED 5-20-46 M. R. Thurst (Address) Prandywine, Md

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May 17, 1946
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from on May 17, 1946 to May 17, 1946
 I last saw him alive on May 17, 1946, death is said to have occurred on the date stated above, at 5 P m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: Diabetes mellitus Date of onset _____

Other Contributory Causes of Importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following: Accident, suicide, or homicide? _____ Date of Injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____ (Signed) John E. Bowers M. D.

(Address) Prandywine, Md

MARGIN RESERVED FOR BINDING

V. S. No. 1

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
------------	-------------

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Deceased was patient in Freedman's Hospital
1944 for period of 3 months.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

05064 245

Reg. Dist. No. 289

1. PLACE OF DEATH:

County Prince GeorgesCity or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 mos. 24 days

Hospital, institution, or street address where death occurred:

Leland Memorial HospitalHow long in hospital or institution? 3 mos. 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County 1City or town 2nd
(If outside city or town limits, write RURAL and give nearest town)Street No. 379 Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Herman Phineas Millard

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Mrs. Nettie Millard

7. Birth date of deceased (mo., day, yr.)

Dec. 19, 18766.(c) If alive, give age 65 years

8. AGE: Years Months Days If less than one day

69419hrs.min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Memorial Business

11. Industry or business

12. Name

Oscar Olmstead Millard

13. Birthplace

Mass.

14. Maiden name

Mary Ann Randall

15. Birthplace

Maryland

16. Informant

Leland Memorial Hospital Records

Address

Riverdale Md17. Burial Date thereof May 11-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or cremator

Fort Lincoln

Location

Westinghouse P. Co.

18. Funeral director

Lloyd Kaiser

Address

Laurel Md.19. May 11 46 Car E. Wachter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 19 46 at 4:43 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct 301939May 91946and that I last saw him alive on May 8 19 46

Immediate cause of death

cerebral hemorrhage

DURATION

6 1/2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert S. McHenry M. D. or otherAddress Laurel Md. Date signed

RECEIVED

MAY 14 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9320

CERTIFICATE OF DEATH

Reg. Diat. No. 05065 245

1. PLACE OF DEATH:

County... PRINCE GEORGES

City or town... RIVERDALE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 DAYS

Hospital, institution, or street address where death occurred:

EUGENE LELAND MEMORIAL HOSPITAL

How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County...

City or town... WASHINGTON, D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 1813 BURKE ST., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war...

3.(a) FULL NAME

MOULTROP, ESTELLA MELINDA

3.(b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED

6.(b) Name of husband or wife... FRED COLEY MOULTROP

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Sept. 6 1876

8. AGE: Years 69 Months 8 Days 6 If less than one day hrs. min.

9. Birthplace... NEW YORK
(Town, county, and state)

10. Usual occupation... HOUSEWIFE

11. Industry or business

12. Name... WALTER WARDEN

13. Birthplace... NEW YORK

14. Maiden name...

15. Birthplace...

16. Informant... MRS. HARRIET CREEK

Address 1017 CRITTENDEN ST., N.E., WASH., D.C.

17. Removal Date thereof... 5-13-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... 517 11th St. S.E.

Location... Wash. D.C.

18. Funeral director... W.W. Chambers Co.

Address 517 11th St. S.E.

19. Date rec'd by registrar... May 13 1946 James Seriz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 12 1946 at 9:21 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 1946 to May 12 1946
and that I last saw him alive on May 11 1946

Immediate cause of death...

Cerebral aneurysm

DURATION

3 days

Due to... Hypertension and its sequelae

Due to... atherosclerosis

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

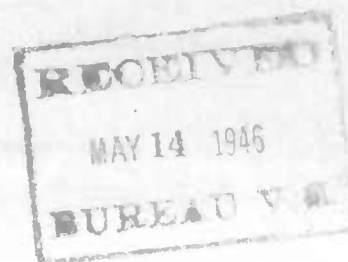
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... James Seriz M.D. or other

Address... Date signed...



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

05066

CERTIFICATE OF DEATH

Reg. Dist. No.

240

1. PLACE OF DEATH:

County Prince George
 City or town Rural Cedarsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George
 City or town Rural Cedarsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Jamie Rebecca Murray

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Francis D. Murray
 6.(c) If alive, give age 68 years
 7. Birth date of deceased (mo., day, yr.) 4-11-48
 8. AGE: Years 68 Months 1 Days 1 It less than one day
 hrs. min.

9. Birthplace Prince George's County
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business

FATHER 12. Name Francis M. Greer
 13. Birthplace Prince George's County
 MOTHER 14. Maiden name Sarah V. Gibbons
 15. Birthplace Prince George's County

16. Informant Claude F. Seger
 Address Brandywine, Md
 17. Burial Date thereof 5-15-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Emmanuel Church
 Location Horsehead, Md

18. Funeral director Fitch Brothers
 Address 4400 Marshall Rd.

19. May 13 1946 F. N. Billingsley
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 12 1946 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
MAY 5 1946 to MAY 11 1946
 and that I last saw her alive on MAY 11 1946

Immediate cause of death RESPIRATORY FAILURE

Due to CEREBRAL HEMORRHAGE

Due to CARDIO-RENAL-VASCULAR DISEASE

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results NONE PERFORMED
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

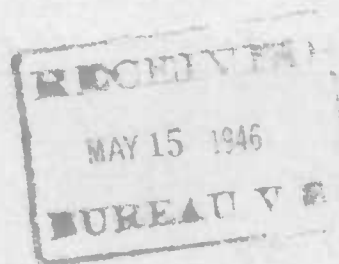
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Alfred Raymond Lakin, M.D.
Agasson, Md. M. D. or other

Address Agasson, Md. Date signed May 13, 1946

DURATION
C.R.V.
DISEASE -
SEVERAL
YEARS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

CERTIFICATE OF DEATH

05067
Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4113-31st. Street.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Frederick Melvin Nash

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Alma H. Nash
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 5, 1888
8. AGE: Years 57 Month Days If less than one day hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual occupation Engineer
11. Industry or business

FATHER
12. Name Melvin Nash
13. Birthplace Va.

MOTHER
14. Maiden name Christine Bonhoff
15. Birthplace Baltimore, Maryland.

16. Informant Alma H. Nash
Address 4113-31st. Street, Mt. Rainier.

17. Burial Date thereof May 17, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Smithland, Md.

18. Funeral director William J. Nalley
Address 3200-R.I. Ave. Mt. Rainier, Md.

19. May 16 1946 James Levery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1946, at 8:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3 1944, to May 14 1946.
and that I last saw him alive on May 14, 1946.

Immediate cause of death

Myocardial failure

DURATION

1 hr.

Due to

Hepatic cirrhosis7 yrs;

Due to

Chronic nephritis3 yrs;

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank R. Shea M.D.

M. D. or other

Address

4100-22nd St. N.E.
Wash. D.C.

Date signed

5/15/46

RETURN TO THE ATTORNEY GENERAL

RECEIVED

RECEIVED

MAY 18 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of Mother and father's name is shown on MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G107 9/20/46

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George's

City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or ~~place of death~~

Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 603 Bonifant Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

LOUISE E. NASON

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female white widowed

6.(b) Name of husband xxx Frank A. Nason

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1874

8. AGE: Years Months Days If less than one day
71 9 16 hrs. min.

9. Birthplace Brooklyn, Maine
(Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business

12. Name Albert Hardy, Dudley Metzfiele

13. Birthplace Maine

14. Maiden name Allie Carter, Georgeanna

15. Birthplace Maine

16. Informant Mrs. W. F. Steiner, daughter

Address 603 Bonifant St., Silver Spring

17. Cremation Date thereof May 10, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Crematory

Location Bladensburg Rd., Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Maryland

19. May 8 1946 James Seery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8-46 19 46 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6, 1946 to May 8, 1946 and that I last saw her alive on May 4, 1946

Immediate cause of death

Carcinoma of uterus DURATION 3 yrs

Due to Metastatic Carcinoma of abdomen

Due to and neck glands

Other conditions Cystitis

(Include pregnancy within 3 months of death)

Major findings of operations not operated by me

Date of op.

Autopsy results yes as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lead H. Calvert Md M. D. or other

Address 7894 Georgia Ave. Date signed 5-8-46

RECEIVED

MAY 10 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-8

of deceased is shown on FILM No. I O 4 MAY 31 1946 CERTIFICATE OF DEATH

05069231
Reg. Dist. No.**1. PLACE OF DEATH:**

County Pro. Georges County
 City or town Cottage City Md.
 (If outside city or town limits, write RURAL and give nearest town)
19 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pro Geo Co.
 City or town Cottage City Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4022 Parkwood st.,
 (If rural, give LOCATION)
 2.(a) If veteran, name War

3.(a) FULL NAMEFlora M. Newmaker**3.(b) Social Security Number**

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white married

6.(b) Name of husband or wife P. J. Newmaker7. Birth date of deceased (mo., day, yr.) Aug. 28, 1887. 8. AGE 58 Years Months Days If less than one dayB.(c) If alive, give age 62 years

Years	Months	Days	If less than one day
<u>59 years</u>			

9. Birthplace Franklin Pa.
(Town, county, and state)10. Usual occupation at home

11. Industry or business

12. Name Wm A. Swartzlander13. Birthplace Pa14. Maiden name Mary Kearns15. Birthplace Pa16. Informant P. J. NewmakerAddress Cottage City Md.17. Burial Date thereof May 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory National Capital ParkLocation Muirkirk Maryland18. Funeral director F. Gasch's SonsAddress Hyattsville Md.19. 5/23 46 Amanda Dourney
(Data rec'd by registrar) Registrar**MEDICAL CERTIFICATION**2D. DATE OF DEATH May 22, 1946 19 1:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-25 19 44 to 5-22 19 46and that I last saw him alive on 5-22 19 46

Immediate cause of death

Mitral Stenosis - CardiacRheumatic Heart Disease

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE W. B. ... M. D. or otherAddress Int. Rainier Rd. Date signed 5-23-46

RECEIVED

MAY 25 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05070

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 mo., 11 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 1 mo., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 618 C. St. S. E.
 (If rural, give LOCATION)
 2.(a) if veteran, name war _____ ✓

3. (a) FULL NAME

OLIVER, JAMES

3. (b) Social Security Number

579-16-1702

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 24, 1916
 8. AGE: Years 30 Months - Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Sumter, South Carolina
 (Town, county, and state)
 10. Usual occupation Presser
 11. Industry or business Tailor Shop - D. Sinrod
 12. Name John Oliver
 13. Birthplace Sumter, South Carolina
 14. Maiden name Mattie Canty
 15. Birthplace Sumter, South Carolina

16. Informant Decedent
 Address _____
 17. Removal
 (Burial, cremation, or removal. Which?) Date thereof May 24, 1946
 (month) (day) (year)
 Cemetery or crematory _____
 Location to Washington, D.C.
 18. Funeral director Barnes & Matthews
 Address 612 - 4th - S.W.
 19. May 23, 1946 Rowland D. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1946 at 11:27 p. M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/12 1946 to 5/23 1946
 and that I last saw him alive on 7/23 1946

Immediate cause of death _____ DURATION
pulmonary tuberculosis 30 mws.
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane M.D. M. D. or other
Glenn Dale, Md. Address _____ Date signed 5/23/46

RECEIVED

MAY 31 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (312)

CERTIFICATE OF DEATH

05071

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges
 City or town Forestville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 years
 Hospital, institution, or street address where death occurred:
Westphalia Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Forestville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Westphalia Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Harriett Rebecca Padgett

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife George Washington Padgett 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) January 16, 1863
 8. AGE: Years 83 Months 3 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Home
 12. Name Henry Fursty
 13. Birthplace Maryland
 14. Maiden name Elizabeth Fursty
 15. Birthplace Maryland

16. Informant Mrs. E. B. North
 Address Forestville, Md.
 Date thereof May 6, 1946
 (Burial, cremation, or removal. Which?)

Cemetery or crematory Forestville, Episcopal Cemetery
 Location Forestville, Md.

18. Funeral director J. W. Lee's Sons Co
 Address 305-4 St. N.E. - Wash. D.C.

19. May 3 1946 Thos S. Griffith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1946 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____, and that I last saw him _____ alive on _____ 19____.

Immediate cause of death Myocardial infarction
 Due to Cardiovascular renal disease
 Due to _____
 Other conditions Bronchopneumonia
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE James D. P. Ford M. D. or other _____
 Address Forestville, Md. Date signed 5-3-46

RECEIVED
MAY 18 1946
BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

CERTIFICATE OF DEATH

05072

Reg. Dist. No. 245

1. PLACE OF DEATH:

County... Prince George

City or town... Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

6003 - 44th Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince George

City or town... Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6003 - 44th Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Marion Edgar Page

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1946 at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h... alive on 19...

Immediate cause of death

Nervous shock

Due to

gun shot wound

Due to

chest

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

6.(b) Name of husband or wife Florence Smith Page

7. Birth date of deceased (mo., day, yr.) February 14, 1898

8. AGE: Years Months Days If less than one day

48

9. Birthplace West Virginia

(Town, county, and state)

10. Usual occupation Mechanic

11. Industry or business Sewing machine

12. Name William Thomas Page

13. Birthplace Bluefield W. Va

14. Maiden name Mary Elizabeth Burton

15. Birthplace Cambridge, Ind

16. Informant Jesse Page

Address 4726 Baltimore, Hyattsville

17. Burial Date thereof May 25, 1946

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Ind

Location near Washington St. E.

18. Funeral director F. Gabcho's sons

Address Hyattsville Ind.

May 26 1946

(Date rec'd by registrar)

James E. Evers

Registrar

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date of 5-23-46

Where did injury occur? Hyattsville P. G. Ind

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury that self with pistol Injured at work? no

Report made by medical examiner

23. SIGNATURE James D. Evers

Address 7 Westview

Date signed 5-23-46

STATE OF VERMONT STATE OF NEW YORK

DEPT. OF STATE

RECEIVED
MAY 25 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

05073

Reg. Dist. No. 240

1. PLACE OF DEATH:

County Prince George

City or town Cheltenham
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Cheltenham
(If outside city or town limits, write RURAL and give nearest town)

Street No. Dean Highway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alice Boyle Cyles

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

John B. Cyles

7. Birth date of deceased (mo., day, yr.)

October 1 - 1874

6.(c) If alive, give age..... years

8. AGE:

Years

71

Months

7

Days

27

If less than one day

hrs. min.

9. Birthplace

Ireland
(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

Nicholas Boyle

12. Name

Dylan

13. Birthplace

Bridget Byrnes

14. Maiden name

Dylan

15. Birthplace

William L. Cyles

16. Informant

957-N. Hill Rd., Balto., Md.

17. Burial

Cheltenham Methodist

Cemetery or crematory

Cheltenham, Md.

Location

Pitchie Blvd.

18. Funeral director

Upper Marlboro, Md.

Address

May 30 1946

(Date rec'd by registrar)

7. H. Pullinsley
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1946 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1946 to May 28 1946

and that I last saw her alive on May 28 1946

Immediate cause of death

Acute Coronary Thromboses

Due to

General Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul E. Van Natta

Washington 19 Date signed May 28 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1946
BUREAU V. 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1372)

CERTIFICATE OF DEATH

C5074 248
Reg. Dist. No.

1. PLACE OF DEATH: Pro Geo Co
County.....
City or town..... Riverdale Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 20 years
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Maryland Pro Geo Co
State..... County.....
City or town..... 4616 Queensbury Rd
(If outside city or town limits, write RURAL and give nearest town)
Street No..... Riverdale Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Ruppert Leo Reid

3. (b) Social Security Number

4. Sex..... male
5. Color or race..... white
6. (a) Single, married, widowed, or divorced..... divorced
6. (b) Name of husband or wife..... Geniece Lee Reid
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... June 23, 1901
8. AGE: Years..... 44 Months..... 10 Days..... 23 It less than one day..... hrs. min.

9. Birthplace.....
(Town, county, and state)
10. Usual occupation..... Crain operator
11. Industry or business..... Smith's Sand and gravel Co
12. Name..... John R. Reid
13. Birthplace..... Virginia
14. Maiden name..... Mary C. Mattingly
15. Birthplace..... Maryland

16. Informant..... Malcolm Reid
Address..... 5028 Cathedral ave.,
Washington D. C.
17. Burial Date thereof..... May 18, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Fort Lincoln
Location..... Washington D. C.

18. Funeral director..... F. Gasch's Sons
Address..... Hyattsville Maryland.

19. May 18, 46 James Severy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 16 19 46 at 2:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
..... 19....., to..... 19.....
and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

DURATION

Acute congestive heart failure

Due to..... Cardiovascular renal disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Deputy Medical Examiner

23. SIGNATURE..... James D. Severy M. D. or other

Address..... Forestville, Md. Date signed..... 5/17/46

RECEIVED BY BUREAU OF INVESTIGATION

RECEIVED BY BUREAU OF INVESTIGATION

ADD: 3

Handwritten signature

RECEIVED BY BUREAU OF INVESTIGATION

RECEIVED BY BUREAU OF INVESTIGATION

RECEIVED BY BUREAU OF INVESTIGATION

RECEIVED
MAY 21 1946
BUREAU V.S.

0417276

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 05075 245

1. PLACE OF DEATH:

County Prince George

City or town Mt Rainier, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Mt Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4006- 29th St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Lloyd B. Rinehart

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male

White

Divorced

6.(b) Name of husband or wife Althea

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1898

8. AGE: Years 47 Months Days It less than one day hrs. min.

9. Birthplace Chewsville, Md
(Town, county, and state)

10. Usual occupation Upholaterer

11. Industry or business Pullman Co

12. Name William Rinehart

13. Birthplace Md.

14. Maiden name Mary M. Summers

15. Birthplace Md.

16. Informant Ben M. Rinehart (Brother)

Address

17. Removal. Date thereof May 2, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Funeral Home

Location 2901-14th St. N.W. Wash. D.C.

18. Funeral director The S. F. Ames Co

Address 2901-14th St. N.W. Wash. D.C.

19. May 2, 1946 James Perry

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1946, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 6, 1945, to May 2, 1946

and that I last saw him alive on May 1, 1946

Immediate cause of death Hypertensive Pneumonia

DURATION

9 days

Due to Cardiac & vascular

renal disease

6

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address 1927 Rock St Date signed May 2, 1946

RECEIVED

MAY 5 1946

BUREAU V N

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05076 243.

1. PLACE OF DEATH:

County Prince George's
City or town (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 29 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1347 T. St. N. W. Apt. #2
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

LOTTIE LEE ROBINSON

3. (b) Social Security Number

—

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married (separated)

8.(b) Name of husband or wife Benjamin Robinson

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) October 27, 1894 ?

8. AGE: Years 51 ? Months 6 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Lynchburg, Virginia
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name James Burton

13. Birthplace Lynchburg, Virginia

MOTHER 14. Maiden name Ophelia Rose

15. Birthplace Lynchburg, Virginia

16. Informant Decedent

Address _____

17. Removal Date thereof May 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Washington, D. C.

18. Funeral director Frazier Funeral Service

Address 389 R. C. Ave. N. W. D. C.

19. May 25, 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 25 1946, at 7⁰⁰ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 26 1946, to MAY 25 1946
and that I last saw him 24 alive on MAY 25 1946

Immediate cause of death PULMONARY TUBERCULOSIS DURATION 3 mos

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane MD
M. D. or other _____
Address Glenn Dale, Md. Date signed 5/25/46

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 31 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

05077

Reg. Dist. No. 232

1. PLACE OF DEATH

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

78

7

29

12 hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. May 23 46

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 19 1946 at 12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 25 1942 to May 19 1946

and that I last saw him alive on May 15 1946

Immediate cause of death

DURATION

Broncho-pneumonia 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAY 25 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1372

CERTIFICATE OF DEATH

05078

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George'sCity or town Riversdale Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month + 1 day

Hospital, institution, or street address where death occurred:

Leland Memorial HospitalHow long in hospital or institution? 1 month + 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince George'sCity or town Riversdale
(If outside city or town limits, write RURAL and give nearest town)Street No. 6309 Somerset Rd.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mr. John Walter Smith4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mrs. Ida Smith

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 7, 19418. AGE: Years 85 Months 1 Days 4 If less than one day _____ hrs. _____ min.9. Birthplace Prince George's Co., Md.
(Town, county, and state)10. Usual occupation Retired Carpenter

11. Industry or business

12. Name Thomas Richard Smith13. Birthplace Prince George's Co., Md.14. Maiden name Violetta King15. Birthplace Prince George's Co., Md.16. Informant Leland Memorial Hosp RecordsAddress Riversdale, Md.17. Burial Date thereof May 14, 1946
(Burial, cremation, or removal. Which?) (Month) (day) (year)Cemetery or crematory Grave HillLocation Laurel Md18. Funeral director F. Giesche SonsAddress Spatterville Md.19. May 13 1946 James Severy
(Date read by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1946 at 7:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 14 1946 to May 12 1946and that I last saw him alive on May 11 1946

Immediate cause of death

Breuchopneumoniahypertrophyrecent surgery

Due to

Due to

Other conditions ArteriosclerosisCerebral & generalized

(Include pregnancy within 3 months of death)

Major findings of operations BreuchopneumoniaHypertrophyDate of op. 5-1-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Signature Lowland Thelkner MD

M. D. or other _____

Address _____ Date signed 5/12/46

RECEIVED

MAY 14 1946

BUREAU V

1744
85
1841

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George
 City or town Fort Washington, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 days
 Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
 How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town Oxon Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6250 Livingston Road S.E.
 (If rural, give LOCATION) ★
 2. (a) If veteran, name war World War I

3. (a) FULL NAME

STECK, John R.

3. (b) Social Security Number

564-07-0672

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mrs. John Steck - FLSIE
 6. (c) If alive, give age 39 years
 7. Birth date of deceased (mo., day, yr.) 11-14-1885
 8. AGE: Years 60 Months 6 Days 16 If less than one day hrs. min.

9. Birthplace Welsh Run, Pa.
 (Town, county, and state)
 10. Usual occupation Plasterer
 11. Industry or business Self employed
 12. Name Luther R. Steck
 13. Birthplace Fairview, Md.

14. Maiden name May Rose Kiser
 15. Birthplace Welsh Run, Pa.

16. Informant Hospital Records
 Address Fort Washington, Md.

17. Burial Date thereof 6/1/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National Cemetery
 Location Arlington, Va.

18. Funeral director W.W. Chambers Co.
 Address 517 11th. St. S.E., Washington, D.C.

19. 5/31/46 19 Wm D. English
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1946, at 2:35A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 15 1946, to May 30 1946
 and that I last saw him alive on May 29 1946

Immediate cause of death Coronary Arterio-
sclerotic Heart Disease with
cardiac enlargement and Myocardial
insufficiency.

DURATION
about
3 yrs.

Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None
 Date of op.

Autopsy results Not done
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Ingram C. Taylor
Ingram C. Taylor, M.D., Acting Commr.
 Address Ft. Washington, Md. Date signed 5-30-46

RECEIVED

JUN 8 1946

BUREAU V.S.

RECEIVED

JUN 8 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05080

Reg. Dist. No. 245

1. PLACE OF DEATH
 County Pro Georges County
 City or town University Park Md
 (If outside city or town limits, write RURAL and give nearest town)
21 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Pro Geo Co.
 City or town University Park Md.
 (If outside city or town limits, write RURAL and give nearest town)
4209 Sheridan st.
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war World war No 1 ★

3. (a) FULL NAME
Dr. William Abbey Turner

3. (b) Social Security Number
 -

4. Sex <u>Male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>
8. (b) Name of husband or wife <u>Marie Woodward Turner</u>		
7. Birth date of deceased (mo., day, yr.) <u>May 13, 1887</u>		
8. AGE: Years <u>59</u>	Months	Days
If less than one day hrs. min.		

9. Birthplace Great Barrington Mass
 (Town, county, and state)
 10. Usual occupation Chemist
 11. Industry or business Dept of Agriculture

FATHER	12. Name <u>Noble Bidwell Turner</u>
	13. Birthplace <u>Massachusetts</u>
MOTHER	14. Maiden name <u>Emma Jane Abbey</u>
	15. Birthplace <u>Massachusetts</u>

16. Informant Marie Woodward Turner
 Address University Park Md.

17. Burial Date thereof May 23, 1946.
 (Burial, cremation, or removal. Which?) (month) (day) (year)
Fort Lincoln Cemetery
 Cemetery or crematory
Washington D. C.
 Location
F. Gasch's Sons

18. Funeral director
 Address Hyattsville Maryland.

May 23 1946 James Serry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1946 19..... 2:33 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 1, 1946 to May 20, 1946
 and that I last saw him alive on May 20, 1946

Immediate cause of death Cerebral hemorrhage DURATION 4 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations Cerebral hemorrhage Date of op. Apr 10/46

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury Injured at work?

23. SIGNATURE James Serry M. D. or other

Address 4108 J. P. Lane Date signed May 24/46

RECEIVED

MAY 25 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 330

05081

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince GeorgeCity or town Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Geo.City or town Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Prince Geo.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Vernon

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (d) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

June Phair Wachter

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 25 1908

8. AGE:

Years

Months

Days

If less than one day

37414

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

Garage

FATHER

12. Name

J. W. Wachter

13. Birthplace

Fredrick C. Md.

MOTHER

14. Maiden name

Cora Foxwell

15. Birthplace

Maryland

16. Informant

Mrs. Eckhart

Address

Baltimore, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 13, 1946
(month) (day) (year)

Cemetery or crematory

Ivy Hill

Location

Laurel, Md.

18. Funeral director

DeWitt Donaldson

Address

105 Main St., Laurel, Md.

19.

(Date filed by registrar)

19

46

M. Brachese

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11-46 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-11-46 to 5-11-46and that I last saw him alive on 5-11-46

Immediate cause of death

Coronary Thrombosis
Myocarditis

DURATION

5 11 461 yr10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Laurel, Md. Date signed 5-11-46

CERTIFICATE OF DEATH

RECEIVED
MAY 15 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on

2411 N. Charles St., Baltimore 13170

CERTIFICATE OF DEATH

05082

Reg. Dist. No. 231

FILM No. I O 4 MAY 13 1946

1. PLACE OF DEATH Bro George Co.
County Stantonville Md
City or town 6 years
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Bro Geo Co
City or town Stantonville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Sheriff Road
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

James Homer alexander Washington

3. (b) Social Security Number

4. Sex male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Ida E. Washington
6. (c) If alive, give age 38 years
7. Birth date of deceased (mo., day, yr.) Oct 10 1899
8. AGE: Years 46 Months 47 Days hrs. min.

9. Birthplace Ta Labor
10. Usual occupation West Bro Brick Co.
11. Industry or business Silas W. Washington
12. Name Ta
13. Birthplace Emma Ware
14. Maiden name Ta
15. Birthplace Ida E. Washington

16. Informant Ida E. Washington
Address Stantonville Md
17. Burial May 6, 1946.
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Methodist Cemetery
Location Bladensburg Md.
18. Funeral director E. Casch's sons
Address Stantonville Md
19. 5/6 46 Amanda Durney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 46, 530 A.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him alive on 19

Immediate cause of death Acute congestive heart failure
Due to cardiovascular renal disease
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Deputy medical examiner
Address Stantonville Md Date signed 5-3-46

RECEIVED

MAY 7 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age of deceased is shown on

FILM No. I 04 JUN 3 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1342

CERTIFICATE OF DEATH

05083

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George's

City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Riggs Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Riggs Road (R.F.D.)
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Novel Clayton Welch

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Isabelle Welch

6. (c) If alive, give age

45 years

7. Birth date of deceased (mo., day, yr.)

July 1, 1902

8. AGE:

Years 43 Months 45 Days 5 If less than one day
hrs. min.

9. Birthplace

Iowa
(Town, county, and state)

10. Usual occupation

Builder

11. Industry or business

Welch

FATHER

12. Name

Welch

13. Birthplace

Iowa

MOTHER

14. Maiden name

Ellyia Schosley

15. Birthplace

Iowa

16. Informant

Lucille K. Welch
Address Riggs Road, Hyattsville

17. (Burial, cremation, or removal, Which?)

Burial Date thereof May 25, 1946
(month) (day) (year)

Cemetery or crematory

Arlington National Cemetery

Location

Arlington Va.

18. Funeral director

R.W. Chambers Co.

Address

Riverside Md.

May 25 19 46 Jones Berry
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 20 21, 1946 at 9:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to19.....

and that I last saw him.....alive on19.....

Immediate cause of death

Acute congestive heart failure
Cardiovascular
renal disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James D. Jones M. D. or other

Address Forestville Date signed 5-22-46

Evidence for change of date of death is shown on

FILM No. I 06 AUG 21 1946

RECEIVED

MAY 25 1946

BUREAU V.S.

ASSIGNMENT LEDGER

FOR COM. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1370

CERTIFICATE OF DEATH

05084

Reg. Dist. No. 232

1. PLACE OF DEATH:

County Prince Georges

City or town Cheltenham
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

North Kemp Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Cheltenham
(If outside city or town limits, write RURAL and give nearest town)Street No. North Kemp Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Matthe Jane West

3. (b) Social Security Number

4. Sex Female

5. Color or race Colored

6. (a) Single, married, or divorced married

6. (b) Name of husband or wife Emanuel West

7. Birth date of deceased (mo., day, yr.) 1980

6. (c) If alive, give age years

8. AGE: Years 66

Months

Days

If less than one day

hrs.

min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business Own Home

12. Name William

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Leaside West
Address Cheltenham, Md

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Removal to West, Md

Location

18. Funeral director W. Bruce Jarman

Address 1432-4th St. N.W. Wash. D.C.

19. (Date rec'd by registrar) 28 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1946 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

acute congestive
heart failure
cardiovascular
renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Deputy Medical Examiner

Address Freshfields Date signed 5/27/46

RECEIVED
MAY 29 1946
BUREAU V.B.

AMERICAN LEDGER

NO CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

05085 231
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George's CountyCity or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 yrs.

Hospital, institution, or street address where death occurred:

Prince Georges General HospitalHow long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 5803 - "M" St. S.E.
(If rural, give LOCATION)2.(a) If veteran, name war ☒

3. (a) FULL NAME

Charles Rittenhouse Wharton

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married6. (b) Name of husband or wife Anna M. Rittenhouse

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 4 - 18858. AGE: Years Months Days If less than one day
60 10 16 _____ hrs. _____ min.9. Birthplace Philadelphia, Pennsylvania
(Town, county, and state)10. Usual occupation Piano maker

11. Industry or business

12. Name Charles Rittenhouse13. Birthplace Pennsylvania14. Maiden name ?15. Birthplace ?16. Informant Anna M. RittenhouseAddress 5803 - "M" St. S.E.17. Burial Date thereof May 22/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar HillLocation Suitland Md.18. Funeral director W.W. Chambers & Co.Address 517 - 11th St. S.E. D.C.19. 5/20 46 Amanda Dourney
(Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 46 at 2:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 19 46 to May 20 19 46and that I last saw him alive on _____ 19 _____Immediate cause of death Cerebralhemorrhage

DURATION

3 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John P. Clum M.D.Address Agattonville Rd Date signed 5-20-46

RECEIVED

MAY 21 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-6)

CERTIFICATE OF DEATH

05085

Reg. Dist. No. 239

1. PLACE OF DEATH: Prince George
 County
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24; 11 M. 1 D.
 Hospital, institution, or street address where death occurred:
 Laurel Sanitarium
 How long in hospital or institution? 2 Yrs; 11 M. 1 D.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2103 Whittier Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

WILHELMINA W. WINCH

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8 - 1860

8. AGE: Years 85 Months 9 Days 25 If less than one day hrs. mlo.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation House work

11. Industry or business

12. Name John Jacob Winch

13. Birthplace Germany

14. Maiden name Margaret Baker

15. Birthplace Germany

16. Informant Sanitarium Records

Address Laurel San., Laurel, Maryland

17. Burial Date thereof 6/3/1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Hagerstown, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. June 1, 1946 A.W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1946 at 145 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1943 to May 31 1946
 and that I last saw her alive on May 31 1946

Immediate cause of death DURATION

Internal Obstruction 3 days

Due to

Due to

Other conditions Emphysema

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John L. Wethered, M.D.

Address Laurel, Maryland

Date signed 5/31/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

05087 245
Reg. Dist. No.

FILM No. I 0 4 MAY 15 1946

1. PLACE OF DEATH:

County Pro Georges Co Md
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Pro Geo Co
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 04906-42 place
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Molloy Winstead

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Ide M Winstead6.(c) If alive, give age 41 years7. Birth date of deceased (mo., day, yr.) Sept 28, 18968. AGE: Years 48 Months 54 Days 54 If less than one day hrs. min.9. Birthplace Ky
(Town, county, and state)10. Usual occupation Boys Printing office11. Industry or business Printer12. Name Kimbley Winstead13. Birthplace Ky14. Maiden name Harriet Leaman15. Birthplace Ky16. Informant Ide M. WinsteadAddress Hyattsville Md.17. Burial, cremation, or removal (Which?) Burial Date thereof May 8, 1946
(month) (day) (year)Cemetery or crematory Fort LincolnLocation Washington D.C.18. Funeral director F Pasche sonsAddress Hyattsville Md.19. Inaug James Severy

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 5/5 1946 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/19 1946 and that I last saw h. 5/5 alive on 5/5 1946Immediate cause of death Coronary Occlusion DURATION 5 1/4

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George Hageagen M. D. or otherAddress 311-38th Ave Date signed 5/5/46

RECEIVED

MAY 8 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 582

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:
 Prince George Co
 County.....
 Silver Hill Maryland.
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Life
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland Pr. Geo. Do.
 State..... County.....
 Silver Hill, Maryland.
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 4018- Branch Ave. S. E.
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 Edmund Earl Wood

3. (b) Social Security Number

4. Sex Male
 5. Color or race White
 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) April 20th. 1932
 8. (c) If alive, give age..... years

8. AGE: Year 14 Month Days It less than one day
hrs.min.

9. Birthplace Silver Hill Maryland.
 (Town, county, and state)
 Student

10. Usual occupation.....

11. Industry or business.....

12. Name Earl E. Wood

13. Birthplace D. C.

14. Maiden name Lillian E. Latimer

15. Birthplace Maryland

16. Informant Mrs. Lillian E. Wood

Address 4018- Branch Ave. S. E. Silver Hill, Md

Burial May 18th. 1946

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory St. Barnabas Cemetery

Location Oxon Hill, Maryland.

18. Funeral director Thomas F. Murray

Address 2007- Nichols Ave. S. E. Wash., D. C.

19. May 15 1946 (Date used by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1946, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1946 to May 15 1946

and that I last saw him alive on May 14 1946

Immediate cause of death

Rheumatic fever

c. endocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hewittman

Address 2015 Nichols Ave. S. E. Date signed 5/15/46

RECEIVED
MAY 28 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County... Prince George's County

City or town... Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince George's

City or town... Cheverly
(If outside city or town limits, write RURAL and give nearest town)Street No. 3013 Laurel Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ann Elizabeth Wright

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white Single

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) May 11- 1946

8. AGE: Years Months Days It less than one day
3 hrs. min.9. Birthplace... Cheverly, Prince George's County, Maryland
(Town, county, and state)

10. Usual occupation... infant

11. Industry or business

12. Name... Oreville K. Wright

13. Birthplace... Duncan, Oklahoma

14. Maiden name... Elizabeth Hooper

15. Birthplace... Elgin, Oklahoma

16. Informant... Oreville K. Wright

Address 3013 Laurel Ave., Cheverly, Maryland

17. Cremation Burial, cremation, or removal. Which? Date thereof 5/14/46
(month) (day) (year)

Cemetery or crematory Prince George's General Hospital

Location Cheverly, Md.

18. Funeral director... A. R. Brasley, Superintendent

Address same

19. 5/22 46 Amanda Dourney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1946 at 8:56 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-11-1946 to 5-13-1946 and that I last saw him alive on 5-12-1946.

Immediate cause of death Bilateral Congestive pneumonia

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Same -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address H. G. Hall, Col. Date signed 5/16/46

RECEIVED
MAY 24 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(1312)

CERTIFICATE OF DEATH

05089

245



Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Prince Georges
 City or town Brentwood
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3.4 years

Hospital, institution, or street address where death occurred:

3413 - Webster

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)Street No. 3413 - Webster
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Harry Wynn

3. (b) Social Security Number

4. Sex male5. Color or race white6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife

Carrie E. Wynn

7. Birth date of deceased (mo., day, yr.)

Jan 15, 1878

6. (c) If alive, give age _____ years

8. AGE:

Years 65

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Illinois

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

MOTHER FATHER

12. Name

Thomas Wynn

13. Birthplace

Kentucky

14. Maiden name

Charity White

15. Birthplace

Kentucky

16. Informant

Carrie E. Wynn

Address

3413 - Webster Street

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

May 17, 1946

Cemetery or crematory

Arlington Cemetery

Location

Arlington Va

18. Funeral director

F. Gasch's sons

Address

Hyattsville Md.

19. (Date rec'd by registrar)

19. 46James E. Leary

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 14 19. 46 at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. _____, to

19. _____

and that I last saw h. _____ alive on

19. _____

Immediate cause of death

Acute congestive heart failure

Due to

Coronary vascular renal disease

Due to

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 5-14-46

RECEIVED
MAY 18 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince GeorgesCity or town Prince Georges
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

Maple Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Prince Georges
(If outside city or town limits, write RURAL and give nearest town)Street No. Maple Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edward Francis Young

3. (b) Social Security Number

717-07-6580

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Oct 1891

8. AGE:

Years

Months

Days

If less than one day

54

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Railroad

MOTHER FATHER

12. Name

Edward Francis Young

13. Birthplace

Maryland

14. Maiden name

Unknown

15. Birthplace

Maryland

16. Informant

Wallace Young

Address

Glendale, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 30 1946
(month) (day) (year)

Cemetery or crematory

Ascension cemetery

Location

Prince Georges

18. Funeral director

Clarence Foreacre

Address

Mitchellville Md.

19. May 29

(Date recd by registrar)

19. 46

W. J. W. Youngling

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19____ to 19____

and that I last saw him alive on 19____

Immediate cause of death

acute pulmonaryedemaDue to acute congestive heartfailureDue to cardiovasculardisease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work? _____

deep medical exam

23. SIGNATURE

James J. Ford

M.D. or other

Address Mitchellville Md Date signed 5-27-46

RECEIVED

MAY 31 1946

BUREAU V S.